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Reply

We would like to thank Dr. Taggart for his interest in our study (1) and his thoughtful comments. We would like to address each point separately.

Dr. Taggart states that: "Rather than presenting total mortality, which is obligatory for reporting of surgical outcomes, they present the incidence of cardiac death, according to the Academic Research Consortium definition. This sets a dangerous precedent, as cardiac mortality is a less objective outcome measure than total mortality, and a better compromise would be to present both; presentation of total mortality should, however, remain mandatory."

The main aim of the DELFT registry (1) was to assess long-term clinical outcome among patients undergoing percutaneous coronary intervention for unprotected left main coronary artery disease. Cardiac death is reported because we think this parameter reflects the direct effect of the interventional treatment on patients' prognosis. Cardiac death is reported in concordance with the Academic Research Consortium definition and is specific for and directly related to the treatment under investigation (2). According to the Academic Research Consortium definition, "all deaths are considered cardiac unless an unequivocal non-cardiac cause can be established." Moreover, "any unexpected death even in patients with coexisting potentially fatal non-cardiac disease (e.g., cancer, infection) is classified as cardiac." For this reason, we think that cardiac mortality should not be considered less objective but rather a more specific outcome measure. However, we do accept that concurrent reporting of total mortality adds additional information. In the DELFT registry (n = 358), the incidence of total death at 1 and 3 years was 7% (25 patients vs. 24 cardiac deaths) and 11.2% (40 patients vs. 33 cardiac deaths), respectively. In elective patients (n = 288), total death at 1 and 3 years was 3.8% (11 patients vs. 11 cardiac deaths) and 8.3% (24 patients vs. 18 cardiac deaths). These results are in line with previous reports (3–5).

The second point made by Dr. Taggart is: "During the period of the study, 680 patients underwent coronary artery bypass grafting in the 7 participating centers. There are no data to inform whether coronary artery bypass grafting patients differed systematically from those undergoing stenting in terms of complexity of left main disease, severity of concomitant multivessel coronary artery disease, existence of comorbid conditions, or, indeed, how the decision was made as to which intervention patients would receive."

We would like to point out that we reported the number of coronary artery bypass grafting (CABG) procedures performed concomitantly to give to the reader an idea of the surgical procedural volume in the participating centers over the same time period. It is beyond the scope of the DELFT registry to provide a comparison between CABG and percutaneous coronary intervention, and, therefore, demographic data relevant to CABG cases were not provided. We do intend to address this question with subsequent analyses.

The third point made by Dr. Taggart is that "there is no explicit statement as to whether all interventions were decided by a multidisciplinary team including a surgeon. The increasing tendency to report interventional treatments being based on 'patient or physician preference' is both inadequate and inappropriate because it reduces the likelihood that patients will receive impartial information and, as a consequence, will not ensure that there is, therefore, real patient choice and genuine informed consent. Unless a patient is clearly unfit or unwilling to pursue a surgical option, discussion of all interventions by a multidisciplinary team should be a minimum standard of care."

In response, we would like to note that, as previously described by our group (6), the current standard of care for patients with significant unprotected left main coronary artery disease is to have them evaluated by both an interventional cardiologist and cardiac surgeon and to reach consensus regarding optimal management. In making this decision, the hemodynamic conditions, lesion, and vessel characteristics; presence of comorbidities; quality of arterial and/or venous conduits for grafting; and patient and/or referring physician preference should be considered. This can be done at a multidisciplinary conference or by direct consultation in the acute setting and is standard practice at the contributing institutions in our registry.

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